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Medicare Meets Mephistopheles: Health Care, Government Spending, and Economic Prosperity

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MEDICARE MEETS MEPHISTOPHELES: HEALTH CARE, GOVERNMENT SPENDING, AND ECONOMIC PROSPERITY

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Author's Note

This essay is an edited version of my remarks during the first panel of the *Mississippi College Law Review*'s symposium on health care reform, which was held on February 26, 2010, in Jackson, Mississippi. The essay integrates my prepared comments with my responses to comments and questions during the discussion period. I have also added some further thoughts on several of the issues that are relevant to the subject matter, especially in light of the subsequent passage of a major federal health reform bill.[1]

These remarks are necessarily brief, and they therefore can include only a hint of the issues that arise with respect to a subject as important as health care reform. These remarks do, however, provide an opportunity to describe some of the most important issues at stake in our continuing efforts to improve our health care system: the quality of care available, the number of people to whom care is provided, and the cost of providing that care. In future work, I will expand upon the ideas raised in this essay, focusing in particular on whether the 2010 health care law appears to be succeeding in reducing health care costs.

I. INTRODUCTION

The Great Health Care Debate of 2009–10 finally ended with the passage of the Patient

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[1] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2010) (enacted).

Protection and Affordable Care Act,[2] which was signed into law in March 2010. Despite months of political acrimony, overheated rhetoric, and false assertions by those opposed to the bill, the most important question in the wake of the bill's passage is not whether it will do too much but whether it will do enough. Far from representing a takeover of the health care sector of the economy, the new law leaves unchanged the core model for health care provision and finance in the United States. The law changes the conditions under which health insurance may be offered—and, more importantly, the situations in which it may be denied or withdrawn—but the players will remain the same. The providers, the insurers, and the government programs will all continue to operate under a revised, but fundamentally unchanged, set of rules.

This is not to say that the changes in the law are unimportant. Far from it. Anything that reduces the number of uninsured people in the country by tens of millions[3] (while, sadly, leaving millions more still lacking coverage) is a major event. Doing so with a bill that pays for itself is a surprising achievement as well.[4] Even so, the lack of universal coverage has been one of two major problems with the U.S. health care system. If we have now solved that problem – or, more likely, if we are on our way to solving it, leaving millions to suffer while we inch toward the finish line – then that is a genuine achievement.

The other major problem with health care in the United States; however, remains to be addressed in a serious way. That problem is the high and rising cost of our health care system.[5]

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[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2009), *amended by* Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

[3] DOUGLAS W. ELMENDORF, et al., COST ESTIMATE FOR THE AMENDMENT IN THE NATURE OF A SUBSTITUTE FOR H.R. 4872, INCORPORATING A PROPOSED MANAGER'S AMENDMENT MADE PUBLIC ON MARCH 20, 2010, 9 (March 20, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf

[4] *See, e.g.*, Robert Pear & David M. Herszenhorn, *Democrats Say Health Bill Will Pay for Itself in the Long Run*, N.Y. TIMES, March 18, 2010, http://www.nytimes.com/2010/03/19/health/policy/19health.html.

[5] Paul B. Ginsburg, The Robert Wood Johnson Foundation, *High and Rising Health Care Costs: Demystifying U.S. Health Care Spending*, 16 RESEARCH SYNTHESIS REPORT 1 (2008), *available at* http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf (noting that "premiums for

We currently spend half again as much, as a percentage of our economy, as our major competitors spend on health care.[6] Even so, we ration health care by allowing some people to be denied health insurance (and thus to be denied medical care when they become ill), and we do it through a system that determines who loses insurance coverage and under what conditions. As a result, we have much worse health outcomes in the United States than in almost every other country in the world that has achieved even moderate economic prosperity. That is, even though we spend much more, we get much less.

The underlying problem, of course, is that the market for health care is characterized by what economists call "market failure." In the typical market that students study in Economics 101, the quality of a good is known and unvarying. Therefore, potential buyers of the good can intelligently assess whether to buy the good, comparing the good's price to the benefit that can be expected from consuming the good. In health care, by contrast, the very nature of the transaction is unbalanced, with the consumer of health care generally unable to assess whether the pill, the cream, or the operation that they are being offered is really worth the pain and cost (or even necessary). Second opinions are available, but obtaining them is itself costly (in time and fees), and the resulting information still cannot eliminate the consumer's uncertainty.

Therefore, while it is important and valuable to harness the forces of supply and demand in health care, a health care market cannot be efficient (or equitable) without some kind of policy intervention. Thus, any health care system must involve intermediaries, which often come in the form of government agencies. Health insurers are subject to state-level regulation, and Medicare and Medicaid are responses to the market failure in health care.

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employment-based private insurance increased 114 percent from 1999 to 2007, while earnings increased 27 percent).

[6] *See id.* (noting in 2006 the United States spent "15.3 percent of GDP, compared to an average of 8.9 percent of GDP for all [developed] countries").

Health insurance itself, moreover, suffers from its own important market failures. While health insurance serves the crucial purpose of spreading risk, for-profit insurers still sell their products to people who are anything but well-informed when it comes to how much coverage to buy, what type of coverage they might need, and so on. Even more important, in most areas of the United States, there is no competition among health insurance providers. While multiple insurers provide coverage around the country – WellPoint, Blue Cross, Aetna, etc. – individual Americans (either through their employer, or on their own) rarely have a choice of even two plans. This, too, prevents the health insurance market from producing the positive outcomes that the economics textbooks would otherwise predict.

The result of our haphazard attempts to combat these market failures is the mess that we call the U.S. health care system in 2010. The system has high costs and low benefits. Moreover, because a large fraction of health care costs are covered by government programs, the costs of providing health care show up in government spending and, in the current situation, budget deficits. While the deficit numbers are the focus of the headlines,[7] however, it is the costs of the health care system as a whole that could ruin the country.

The most important goal, in other words, is not to balance Medicare's budget. It is to stop the health care system from devouring the entire economy. If we do that, then the budgets of the government-run programs will necessarily also be brought under control. If we do not bring all health care spending under control, however, even a balanced government health care budget will not save the American economy.[8]

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[7] Roger Runningen and Brian Faler, *Obama Raises 2010 Deficit Estimate to $1.5 Trillion*, BLOOMBERG, August 25, 2009, http://www.bloomberg.com/apps/news?pid=20601087&sid=aNaqecavD9ek.

[8] The first official analysis of the 2010 health care law, in fact, indicates that the new law will reduce the governments' costs of providing medical care. However, overall health care spending will rise by 0.9% over the 2010–19 period, because of the cost of providing coverage to people who are currently uninsured. *See* Robert Pear, *Health Care Cost Increase is Projected for New Law*, N.Y. TIMES, Apr. 24, 2010, at A8.

II. THE UNITED STATES HEALTH CARE SYSTEM IS *NOT* THE BEST IN THE WORLD

In late February 2010, shortly before health reform passed, President Obama hosted a "health care summit" in Washington, D.C. The leaders of both parties in Congress attended the summit, with the stated intention of finding common ground on health care reform.[9] Subsequent events demonstrated that the summit had failed, at least in that respect.[10] It was, however, successful in at least one regard: the summit was open to television cameras, and participants used the event to hammer home their talking points. Representative John Boehner, the Ohio Republican who serves as minority leader in the House of Representatives, repeatedly asserted that the United States currently has "the best health care system in the world by far."[11] Given that we are already number one, he suggested, we should not fix what is not broken.[12]

We do not have the best health care system in the world. In fact, it is not even a close call. While there are aspects of our medical-industrial complex that are truly superior, the system as a whole shows very little evidence of excellence. In this section, I will discuss the ways in which the U.S. system could be called a success, the overall failure of the system, and the mitigating factors that might explain away some or all of the failures of the current system. The overall picture shows an astonishingly wealthy nation that has settled for health care outcomes that much poorer nations have easily exceeded.

A. Measuring Success: The Health of the Population vs. The Availability of High-Level Care

Any health care system has a broad array of inputs and outputs, along with a range of

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[9] WhiteHouse.gov, *A Bipartisan Meeting on Health Reform*, http://www.whitehouse.gov/health-care-meeting/bipartisan-meeting (last visited on May 6, 2010).

[10] Sheryl Stolberg & Robert Pear, *President Urges Focus on Common Ground*, N.Y. TIMES, Feb. 25, 2010, http://nytimes.com/2010/02/26/health/policy/26health.html?scp=1&sq=health+meeting+fails+to+bridge+partisan&st=nyt# (noting that "by day's end, it seemed clear that the all-day televised session might have driven the parties even farther apart.").

[11] Representative John Boehner, House Minority Leader, Remarks Concerning Individual Insurance Mandates at White House Health Summit (Feb 25, 2010), *available at* http://www.washingtonpost.com/wp-dyn/content/article/2010/02/25/AR2010022504251.html.

[12] *Id.*

outcomes that have important effects not only on the individuals involved but also on the society as a whole. As such, there are many criteria that one could use to describe a system as being the "best system in the world." Two possible ways to define systemic quality are: (1) A health care system is the best if the citizens who receive health care through that system have the best outcomes from their medical care, or (2) A health care system is the best if it provides the most technologically advanced medical interventions available, even if it does not provide those interventions to everyone who could benefit from them.

To give Representative Boehner the benefit of the doubt, he could have been describing the U.S health care system as the best in the world based on the latter criteria. If a person has an extremely grave illness, especially an unusual ailment that requires cutting-edge and extremely expensive treatments, then the chances are fairly good that the United States will be one of the few places in the world where that illness can be treated. Although specialized clinics exist around the world, especially in Europe, it is surely true that a person with a rare form of cancer, or something similarly life-threatening, would be wise to look for health care in this country. We are "the best" in the sense that some of the most advanced health care can be purchased here.

The key, of course, is in the word "purchased." If a person has unlimited funds, and they are willing to spend as much as needed on medical care, then they are likely to be able to find the best (or among the best) care in the world somewhere in the United States. The Mayo Clinic and the Cleveland Clinic are only two examples that readily come to mind. Similarly, if a person needs pharmaceuticals, the United States is the home of several companies that produce some of the best medicinal drugs in the world.

The sticking point is price. The issue is not whether we can cure and control more diseases than ever before. We can. The issue is, instead, whether we can do so for more than a

few people without bankrupting them, their employers, or their health care providers – and without committing the government to ever-larger expenditures on high-cost, cutting-edge medical interventions that benefit very few people.

By contrast, the more meaningful measure of the quality of a nation's health care system is the overall health of the population. Rather than asking whether a particular person who is suffering from a particular illness could, at least in theory, receive the latest medical innovations in dealing with that illness, we should ask how many of the citizens of a nation are alive and healthy. By any of the statistics available to assess the performance of the U.S. health care system, our system is far from the best.

For example, the Central Intelligence Agency ("CIA") maintains an extensive database of statistics on the economies, histories, militaries, and other social statistics in virtually every country in the world. "The World Factbook,"[13] as it is called, also contains a wealth of information about health outcomes in 266 countries for which the CIA has gathered data.

It is instructive to look at two of the most fundamental health outcomes: infant mortality and life expectancy. On infant mortality, the CIA provides statistics showing "the number of deaths of infants under one year old in a given year per 1,000 live births."[14] Out of 224 countries listed, using 2009 estimates, the United States is 45th lowest in the world, with 6.22 infant deaths per 1,000 live births.[15] This puts us two spots behind Cuba, which suffers 5.82 infant deaths per 1,000 live births.[16] Singapore has the lowest rate of infant mortality, at 2.31.[17] The second place

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[13] CIA.gov, The World Factbook, https://www.cia.gov/library/publications/the-world-factbook/index.html (last visited on May 6, 2006).

[14] CIA, The World Factbook, *Country Comparison: Infant Mortality Rate* (2009), https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html.

[15] *Id.*

[16] *Id.*

[17] *Id.*

country is Bermuda, with 2.46 deaths per 1,000 live births.[18] Sweden and Japan are third and fourth, with rates of 2.75 and 2.79 respectively.[19]

Most importantly, the infant mortality rate in the United States is worse than any other country to which we might want to compare ourselves. Even including the newest, poorest members of the European Union, that group of nations currently suffers 0.5 fewer infant deaths per 1,000 births than does the United States.[20] We have much worse results than Canada, New Zealand, and Australia.[21] In fact, we fare far worse than Malta, Slovenia, and Macau.[22] Most importantly, the differences between our infant mortality rates and other countries are large. Our rate is more than double that of the top five countries in the world, and we suffer more than one additional infant death per thousand than the thirty-five top countries in the world.[23]

The story is sadly similar with life expectancy. The World Factbook provides estimates for 2009 of "the average number of years to be lived by a group of people born in the same year, if mortality at each age remains constant in the future."[24] Again, the outcomes for the United States are less than impressive. We rank 49th in the world, with a life expectancy of 78.11 years.[25] On this measure, at least, the United States outperforms Cuba, which has a life expectancy of 77.45 years and is ranked 55th.[26] Even so, that is hardly a measure of success: we still fare worse than, for example, Malta (79.44 years, #29).[27] More important, life expectancy in this country is much shorter than in any country to which the U.S. is usually compared: Japan

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[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] CIA, The World-Factbook, *Country Comparison: Life Expectancy at Birth* (2009), https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html.
[25] *Id* ("the average number of years . . . includes *total population* as well as the *male* and *female* components").
[26] *Id.*
[27] *Id.*

(82.12), Australia (81.63 years, more than three and a half additional years compared to the U.S.), Canada (81.23), France (80.98), Italy (80.20), and the United Kingdom (79.01).[28] We even fare worse than Bosnia and Herzegovina (78.50).[29]

The overall picture, therefore, shows that the United States is far behind other countries in the world in two of the most important measures of the health of a country's citizens. This pattern could be shown for other health outcomes, but the point is that we are falling far short of being "the best" in the world when it comes to keeping our citizens alive.

B. Alternative Explanations for Poor Outcomes in the United States

When dealing with any particular health outcome, of course, there are possible explanations for the poor showing by the United States that go beyond our health care system. As the CIA notes, for example: "Life expectancy at birth is also a measure of overall quality of life in a country."[30] In other words, high rates of infant death and low life expectancies can be caused by factors that go beyond the health care system. Nutritional factors, environmental factors (such as contaminants in the air and water), the average age of a country's citizens, and other factors can all affect a country's citizens' health, even if the country's nurses, doctors, and hospitals are first-rate.

The value of comparisons with all nations in the world, however, is that we do not have to puzzle over the differences between just two countries. If we were to look solely at the difference between the infant mortality rate in the United States and that in Bermuda, for example, it would be important to look at (among other things) the extreme difference in the size of the two countries. Comparing Sweden to the United States would remind us of the possible importance of cultural homogeneity in health outcomes. Comparing Japan and the United States

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[28] *Id.*
[29] *Id.*
[30] *Id.*

would raise the matter of a country with relatively limited immigration being compared to a country with relatively large flows of immigration.

While any two-country comparison can be explained away by another factor that might be at work, however, the failure of the United States to be competitive with any of the countries in the world that we think of as "advanced" – and our under-performance compared even to relatively poor countries – all but removes any explanation based on unique country-specific factors. While it would be possible to perform a sophisticated statistical analysis, controlling for all known factors affecting national health, the CIA's World Factbook evidence is so stark that it is difficult to imagine that the differences could be explained away by any plausible statistical adjustment. At the very least, we can take the data discussed above as highly suggestive that something is wrong with the U.S. health care system, compared to dozens of other countries. That tentative conclusion can be revised, of course, but it hardly seems reckless to draw such a conclusion based on these data.

There is, in addition, another possible explanation for the difference in health outcomes between the U.S. and other countries. Even if the statistics described above are not in any way corrupt or unreliable in measuring what they purport to measure, they might nonetheless paint a misleading picture of the quality of health care in this country. The leadership role of the United States in providing high-tech health care – "the best" health care in the world in the first sense of that phrase, as discussed above – could actually make the U.S. look systematically worse than it would otherwise look.[31]

How might this work? Suppose that there are high-quality health care facilities in the

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[31] I thank a member of the audience at the symposium for raising this issue. Although he began his comment by saying that he did not "believe" the statistics, it became clear in context that his concern was not that the numbers had somehow been gathered incorrectly but rather that the numbers were statistically biased because of the possible explanation discussed in the text.

United States, providing care that lengthens the lives of any patient who checks in (and can pay the bill). If, say, a Canadian citizen leaves her country and receives care in the United States, then returns to Canada to live out the additional years of her life that were made possible by U.S. medical facilities, Canada's life expectancy rate would increase – not because the Canadian health care system is better, but because the American system is.

This is a very clever point, and it could well contain a germ of truth. Even so, it reflects what I think of as a "lawyerly" argument rather than an "economic argument," in the following sense. Lawyers are generally trained to poke holes in arguments, to think of hypotheticals that could undermine the broad applicability of a legal rule or a Constitutional principle. By contrast, economists are generally trained to think in terms of marginal changes, explaining differences in statistical outcomes.[32] Lawyers like to be able to show that a particular problem will not be completely solved if some particular law or policy is enacted. By contrast, economists say something like this: "I don't believe that I could ever completely explain a problem, but I believe that I can isolate some of the factors at play, and I believe I can determine which are the most important factors versus the least important factors." Whereas a lawyer is successful when, for example, she can show that there is even a minimal reasonable doubt about a client's guilt, or that there is some non-zero risk that some legal principle embodies a slippery slope, an economist is successful when she can explain–at least in part–an observation about the world.

This is an instance, therefore, where the economist in me elbows out the lawyer in me. It is true that a Canadian or a Frenchman or an Australian might come to the United States to buy exotic health care, and that would change the statistics in the way that the questioner at the

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[32] I hasten to emphasize that I generally think that legal training is superior to economics training, in particularly because of the interdisciplinary nature of legal inquiry. The difference in "legal thinking" versus "economic thinking" that I describe in the text is, however, something that I see consistently when I deal with lawyers and law students as opposed to economists and economics students.

symposium suggested. Could that, however, explain the *three full years* of greater life expectancy that we see in Canada?[33] How many Canadians would have to come to the United States and receive successful medical interventions for their country's average life expectancy to be so much higher? An interesting categorical explanation is only useful if it holds up to quantitative scrutiny, and this explanation simply fails that test.

In addition, this explanation is based on a presumption that is almost exactly the opposite of reality. If the United States had a higher life expectancy than Canada, and Canadians came to the United States to receive our superior health care, then the statistical distance between the two countries would be smaller than it otherwise would have been. Importantly, however, the United States would still have a *higher* life expectancy. If the U.S. system is better, after all, it should be better for our citizens, too; and since all of our citizens live here, that should show up in a higher life expectancy in the United States. Yet what we see is not a Canadian outcome that is closer to ours than it would otherwise be. Canadians are living longer than Americans.

The only ways out of this conundrum are either to say that there are other reasons why the U.S. rate is lower (a possibility, if remote, given that the Canadian population so closely mirrors that of the United States), or to note that the citizens of the United States generally do not receive the great care that the occasional wealthy Canadian is receiving in the United States. If that is the explanation, however, then it really amounts to a mere restatement of the idea that "the best" is measured by technological virtuosity rather than improved outcomes for the population as a whole.

In short, the United States has very little basis on which to make a claim that it has the best health care system in the world. While there are many top-flight facilities in this country,

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[33] CIA, The World-Factbook, *Country Comparison: Life Expectancy at* Birth (2009), https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html.

that is not the same as saying that our health care system improves our health as well as it could. We can and must do better.

III. The United States Health Care System is the Most Expensive in the World

While the United States falls far short in measures of health care outcomes, there is one area in which the United States is the world's leader in health care: cost. We currently devote over 16% of our national output[34] to health care, a percentage that has been rising for decades and shows no sign of slowing down.[35] By contrast, the health care systems of the other advanced post-industrial countries in the world absorb on the order of 9-12% of those countries' outputs.[36]

For example, using 2007 data, the OECD reported that the United States spent 16.0% of Gross Domestic Product ("GDP") on health care.[37] The second-place country was France, which spent only 11.0% of its GDP on health care. Canada spent 10.1%, and Sweden (which shows up especially well in the international comparisons of health care outcomes) spent only 9.1%.[38] To put this in perspective, GDP in the United States in the fourth quarter of 2007 was approximately $14.4 trillion.[39] If the country had spent only 11% of GDP on health care in that year, that would have meant a reduction of $720 billion, or $2,400 per capita, in health care spending.

This is, as they say, real money. Moreover, the costs in the United States are rising rapidly. The Congressional Budget Office, for example, estimates that health care will absorb

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[34] The statistics discussed herein use Gross Domestic Product (GDP) as the definition of national income. While there are several variations on GDP as a measure of national income, GDP is the most commonly used; and the differences among the various measures do not affect the analysis herein. Note also that "national output" and "national income" are identically equal in the national income accounts, so they can be used interchangeably.

[35] OECD, OECD Health Data 2009 1 (2009), http://www.oecd.org/dataoecd/46/33/38979719.pdf .

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] Bureau of Economic Analysis, *National Income and Product Tables: Table 1.1.5 Gross Domestic Product* (2010), http://bea.gov (follow "Gross Domestic Product (GDP)" hyperlink; then follow "GDP and the National Income and Product Account (NIPA) Historical Tables" hyperlink; then follow "List of All NIPA Tables" hyperlink; then follow "Table 1.1.5 Gross Domestic Product (A) (Q)" hyperlink).

25% of GDP in 2025.[40] While there is reason for skepticism about some of those longer-term forecasts, as I discuss below, we would have a problem even if health care costs were to stabilize at their current level.

It is also important to put these costs in the context of the outcomes discussed in the previous section of this article. We outspend the rest of the world on health care by a significant amount, yet we have much worse health outcomes than the rest of the world. In terms of bang for the buck, we could not be doing much worse.

A. The Issue is High Health Care Costs for Everyone, Not Just the Government

In policy debates, the focus has typically been on the implications of health care costs for the federal budget. For example, two of the most prominent economists who follow federal budgetary policy, Alan Auerbach and William Gale, have written extensively about the long-term "fiscal gap," which is essentially their estimate of the aggregate long-term budget deficit (expressed in present value).[41] They reported late in 2009 that their pessimistic projections of the long-term fiscal picture were in part driven by Bush-era fiscal policies, but health care was also a major driver of the federal government's budgetary pressures: "The long-term fiscal problem is to some extent a health care spending growth problem, in that the projected growth in Medicare and Medicaid is perhaps the single most important cause of the growing imbalance between projected revenues and expenditures."[42]

I have written skeptically about the fiscal gap estimates on which the Auerbach/Gale

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[40] CONGRESSIONAL BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 2 (2007), http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf [hereinafter CBO].

[41] In addition to Auerbach and Gale, three other economists—Laurence Kotlikoff, Jagadeesh Gokhale, and Kent Smetters—have played key roles in developing and promoting the fiscal gap as an alternative to standard budget accounting. *See* the discussion and citations in Neil H. Buchanan, Social Security, Generational Justice, and Long-Term Deficits, 58 TAX L. REV. 275 (2005).

[42] Alan J. Auerbach and William G. Gale, *The Economic Crisis and the Fiscal Crisis: 2009 and Beyond*, TAX NOTES (SPECIAL REPORT), Oct. 5, 2009, at 103, *available at* http://weblaw.usc.edu/assets/docs/contribute/Auerbach-GaleAGTN2009-10-05.pdf

analysis relies.[43] If those estimates are accurate, however, then our situation truly is scary. For example, in one recent year the fiscal gap was estimated to be over $70 trillion.[44] This is a bit less scary when expressed as a percentage of GDP – Auerbach and Gale put it in the 5-10% range, depending upon the assumptions used to generate the forecast[45]—but the numbers are large in any event. In any case, projected increases in long-term federal deficits are overwhelmingly driven by Medicare costs.[46] (Notably, however, Social Security is *not* an important part of the long-term fiscal problem that Auerbach and Gale claim is on the horizon.)

Of course, every projection is driven by its assumptions; and a projection that purports to summarize the fiscal situation *into the infinite future* is especially sensitive to its assumptions. The Congressional Budget Office, using assumptions similar to the Auerbach/Gale assumptions, projects that health care costs will rise (as noted earlier) to 25% of GDP in fifteen years.[47] Some skepticism is appropriate here, however, because CBO says that "in the absence of changes in federal law," health care spending will rise to 37% of GDP in 2050 and 49% in 2082, with Medicare expenditures alone accounting for 19% of GDP in 2082.[48] This cannot possibly be a realistic forecast. I do not doubt that the published forecasts accurately reflect the outcome of the authors' computer simulation, but surely the behavior of people and businesses would change—even in the absence of changes in the law—if health care inflation were to continue on that path. An economy heading toward a day when half of all its resources would be devoted to health care, as these projections imply, would surely see significant changes in behavior long

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[43] Buchanan, *supra* note 41.

[44] Laurence J. Kotlikoff, *The Emperor's Dangerous Clothes*, ECONOMISTS' VOICE, Apr. 2007, at 1-2, available at http://www.bepress.com/ev/vol5/iss2/art3 ("[F]uture U.S. federal expenditures are $70 trillion more than federal receipts, according to my extrapolation of 2005 fiscal gap accounting by Jagadeesh Gokhale and Kent Smetters.."), citing Jagadeesh Gokhale and Kent Smetters, *Measuring Social Security's Financial Problems*, NBER working paper no. 11060, Jan. 2005...

[45] Auerbach and Gale, *supra* note 42, at 103.

[46] *Id.*

[47] CBO, *supra* note 40, at 2.

[48] *Id.*

before that day arrived.

Skepticism is, therefore, an appropriate response to these long-term fiscal projections. Even so, the underlying economic problem is not really that we are inadequately funding Medicare. The problem is that we are wasting resources on health care. Even if we fully paid for the 19% of GDP that we will supposedly be spending on Medicare in 2082, after all, we would still be devoting (according to those estimates) half of our economy to health care. That cannot possibly be healthy for the economy, no matter the government's budget situation.

Consider the impact of health care costs on the private sector of the U.S. economy. Employer-based health insurance coverage in this country (which, by the way, is an accident of history) is turning out to be ruinous to business. For example, early in 2009, during the debate over whether the federal government should provide bailouts to General Motors and Chrysler, news outlets reported that the average American auto worker cost GM and Chrysler and Ford $73 an hour in combined wage and benefit costs.[49] Although that figure was used – quite inappropriately – to compare U.S. autoworkers' wages to foreign autoworker's wages, the facts underlying the figure do tell an important story.

In fact, the seventy-three dollars in benefit costs paid by the American automakers consists in large part of health care costs paid on behalf of retired American auto workers (so-called "legacy costs").[50] Dividing total employee benefit costs by the current number of workers produces the meaningless number of $73/hour, but the underlying facts still show that current and former employees' health care costs exceed by a wide margin the wages of current workers. It is true, therefore, that health care costs came close to destroying American auto companies.

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[49] *See, e.g.*, CNSNews.com, *Union Workers at Big Three Automakers Average $73 an Hour*, http://www.cnsnews.com/Public/Content/article.aspx?RsrcID=39499, (last visited April 26, 2010).

[50] E.H.H., Media Still Wedded to $70+ Per Hour Autoworker Falsehood Despite GM's Recent Statements to the Contrary, MEDIA MATTERS FOR AMERICA, Dec. 6, 2008, http://mediamatters.org/research/200812060002.

One estimate was that those costs accounted for $5,000 of the price of an American car.[51] Importantly, therefore, this problem cannot be solved even by paying current autoworkers a sub-minimum wage. That would surely increase the companies' profits (or reduce their losses), but the companies' health care costs are still the real problem. If those costs continue to grow, no amount of wage cutting will make the American automobile manufacturers globally competitive.

Moreover, even if the auto companies were allowed to cut off the health benefits of their current and former workers, that would solve the problem only for the auto companies, not for the country as a whole. Those workers and retirees are living people (who, presumably, would like to stay that way), and they will still be there even after any effort to relieve the auto companies of those expenses. (To be clear, I am using the auto companies merely as a high-profile example. The problem of employees' and retirees' health care costs is harming businesses of all sizes and in all industries.)

If people lose their employer-provided health care coverage, they will need to buy their own coverage, but individual policies are rising in price at ever-faster rates. Those who cannot afford individual coverage will either show up on government health care rolls or in emergency rooms, where the costs are higher still. The final alternative is for people to forgo medical care, which does not make the costs of ill health go away. It simply imposes them on a smaller group of people. If anything, it also causes every else's costs to rise, as uninsured people ignore minor (and relatively inexpensive) problems until they develop illnesses that have become unbearable (and very expensive).

The high and rising costs of health care, therefore, are only incidentally a budgetary problem for the federal government (and state governments, through Medicaid). The

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[51] Healthcare2point0.com, *Number Please: Statistics in the Context of Health Care*, http://healthcare2point0.com/numberplease_23aug09.htm (last visited on May 6, 2010).

consequences of our expensive health care system are catastrophic for individuals and businesses alike. The only path forward, therefore, must be to reduce health care costs.

B. Reasons for the High Health Care Costs in the United States

Why does the U.S. health care system cost so much? One of the most interesting analyses of the problem was recently published by a Harvard Medical School professor, Atul Gawande.[52] He found what social scientists would call an almost perfect "natural experiment." He noted that two cities in Texas that are similar in almost every relevant way—rates of obesity, ethnic mix, etc.—have wildly different levels of Medicare costs.[53] El Paso and McAllen are at opposite ends of Texas on the Rio Grande River, and because they are so similar, they provide a helpful window through which to identify what causes health care costs to rise.[54]

After going through a range of possible explanations, Gawande landed on what appears to be the key difference between the two cities. In McAllen (the expensive city), health care professionals had adapted to the "fee-for-service" model in the way that a basic economics textbook would predict: If you pay people for each service that they perform, they will perform more services.[55] In El Paso, by contrast, doctors were not (yet) responding to those economic incentives.[56] Even so, the lower rate of medical interventions in El Paso did not result in worse outcomes for patients.[57]

Ominously, however, things are starting to change in El Paso. Whatever self-control existed there is beginning to weaken, as doctors have evidently begun to act more like the

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[52] Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, THE NEW YORKER, Jun. 1, 2009, at 36, *available at* http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande.

[53] *Id.* at 36-37.

[54] *Id.*

[55] *Id.* at 37-40.

[56] *Id.* at 40-42.

[57] *Id.*

doctors in McAllen.[58] Costs should soon rise accordingly.

In terms of the standard of care, the problem is that the fee-for-service system can actually harm patients. Paying people to operate on patients results inevitably in some unnecessary operations being performed. Not every doctor will succumb to these temptations, of course, but enough will do so to increase costs catastrophically. Therefore, one sensible way to address health care cost inflation is to move away from fee-for-service medicine.

As an aside, it is worth noting that both McAllen and El Paso are in a state which has enacted so-called "tort reform."[59] Even if Texas had not enacted such reform, however, the key point is that both cities are operating under the same malpractice rules. Those who suggest (as did some in the audience during the discussion period at the symposium) that health care costs are driven by the legal system, therefore, will find no support in Gawande's analysis.

IV. Different Kinds of Waste, and How to Reduce Them

In short, we have (either actively or passively) created a health care system in this country that encourages waste. The fee-for-service model would appear to be a prime culprit. Medical care providers are responding rationally to economic incentives: if you do more to people, you will be paid more. It does not matter if patients become healthier or not. In fact, there are no penalties to health care providers if a medical intervention makes a patient *less* healthy. The challenge for policymakers is to find the best ways to eliminate or reduce the waste that results.

A. From Cost vs. Benefit to Cost vs. Harm

If we want to reduce waste, however, it is necessary first to define the concept. In health care, "waste" can have two distinct meanings. What might be called "pure waste" involves

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[58] *Id.* at 44.
[59] *Id.* at 38.

paying money and getting a worse outcome as a result. By contrast, "net waste" might be the best way to describe a situation where costs exceed benefits. There might be real benefits, but they are too small to justify the costs.

One of the most depressing facts about U.S. health care, therefore, paradoxically offers a basis for optimism: The system is engaged in "pure waste" on a massive scale. Because we pay doctors by the procedure, and because at least some doctors respond to that incentive by performing additional procedures (and more intrusive procedures, which are reimbursed at higher levels), large numbers of people are harmed by undergoing unnecessary medical procedures that do not make them healthier. In fact, because medical interventions necessarily involve the risk of side-effects (e.g., staph infections), and because errors are inevitably made during surgeries and other procedures, some people die (and others survive but are still harmed) as a result of receiving medical care that they did not need. People are, for example, receiving stents, pacemakers, and coronary bypass surgeries that do nothing to improve their health.[60]

This is, in other words, "pure waste" in the sense that there is no cost/benefit balancing involved. We pay money, and people are worse off as a result. It might seem that there would be no resistance to eliminating this type of waste, but in fact some people and companies profit handsomely from it. Even getting rid of pure waste, therefore, is more difficult than one might expect.

B. Rationing, Death Panels, and Other Scare Words

In contrast to pure waste, there are certainly situations in which there is a difficult call to be made in terms of weighing genuine benefits against costs. Such calls can be difficult even outside of health care, especially where the elderly are involved. For example, several years ago I attended the commencement ceremony of the college where I was teaching. A woman who

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[60] *Id.*

appeared to be in her seventies received her bachelor's degree, and the crowd (which included a large number of the graduate's children and grandchildren) cheered. One of my colleagues in the Economics Department was unmoved, however. When he saw me smiling and applauding, he asked: "Why do you think she did that?" I replied: "Perhaps the fulfillment of a lifelong dream?" My colleague's response: "What a waste. She is not going to be able to do anything with that degree. Her place in class should have gone to someone who is 22 years old."

The germ of truth in the "death panels" propaganda, therefore, was that some truly difficult calls must be made in any health care system. Those decisions involve saying, in essence, that it is too expensive to keep a person alive. Such decisions are, in fact, made all the time under private health care plans in this country; but the political controversy was based on the idea that it would somehow be worse to have the government's bureaucrats making such decisions, rather than the insurance companies' bureaucrats.

Therefore, dealing with health care waste of the second type ("net waste," or benefits that do not justify the expense) will always be especially sensitive. Given that there is so much waste of the first kind, however, there is a great deal of low-hanging fruit that we can pick long before we would ever need to think about anything resembling "death panels."

It is also worth pointing out that, in the recent political debate over health care costs, any reduction in health care spending was characterized as "taking away people's health care" or "cutting Medicare." People who proposed cost-cutting measures were demonized, accused of wanting to harm people. The goal of reform must be to reduce health care costs, which includes reducing Medicare costs. There is a lot of money that can be saved on things that nobody would defend as useful, and that is where we ought to start. If any reduction in costs is equated with a "cut in health care," then even the most defensible savings will be the victims of demagoguery.

Finally, it is important to emphasize that I am not taking a position here on whether the United States should adopt a fundamentally different kind of health care system. The recent political debate in this country involved some discussion of a "public option," that is, a government-run health insurance plan that would compete with private health insurers (thus guaranteeing that every person in the country would have at least two choices of health insurance providers).[61] Although the Obama administration ruled out a single-payer plan,[62] such as Canada's system, that is also a large-scale option. In the other direction, we could shut down Medicare and Medicaid and run everything through a purely private system.

Although I have strong opinions about those various possibilities,[63] such a discussion is not appropriate here. The point is that, even under the current system, there are opportunities to eliminate waste – and eliminating that waste would save lives as well as money. That is where we should focus our efforts.

V. CONCLUSION

Health care in the United States represents a terrible bargain. We spend much more on health care than does any other country in the world, but Americans are less healthy than citizens in many, many other countries. No matter who pays for our health care – governments, businesses, or individuals – and no matter how they pay for it, we must stop wasting resources on health care. We must stop spending money on medical interventions that make people at best no better off, and which can actually make people worse off. Doing nothing about this situation

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[61] President Barack Obama, Remarks by the President at the Annual Conference of the American Medical Association (June 15, 2009) (transcript available at http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association).

[62] *Id.*

[63] *See, e.g.*, Neil H. Buchanan, *Can the Public Option in Health Care Reform Be Saved? Should It Be?*, FINDLAW.COM, Aug. 13, 2009, http://writ.news.findlaw.com/buchanan/20090813.html; Neil H. Buchanan, *Can the Public Option in Health Care Reform Be Saved? Should It Be (Part II)*?, FINDLAW.COM, Aug. 14, 2009, http://writ.news.findlaw.com/buchanan/20090814.html.

is not only immoral: it is economic suicide.